

**CARDINAL HEALTH
SECURITY DEPARTMENT
INCIDENT REPORT FORM**

Incident Number: _____

Date of Incident: _____ Time: _____

Nature of Incident: _____

Reporting Party: _____

Department/Address: _____ Phone/Ext: _____

Authorities Notified: _____

Explain Incident in Detail: _____

Disposition: _____

Security Officer

Reporting Party

FORM NAME:

ACCESS AND SURVEILLANCE LIST

FORM NUMBER:

DEA # 16

FUNCTION:

Used to facilitate compliance with DEA regulation which requires written authorization for cage and vault access.

CAH_MDL_PRIORPROD_DEA07_01384112

FORM NAME: DELIVERY VEHICLE SECURITY RULES

FORM NUMBER: DEA # 17

FUNCTION: Used to document security measures required by delivery vehicle drivers.

DELIVERY VEHICLE SECURITY

The following rules are intended to promote safety and security for drivers and their delivery vehicles. They are to be complied with at all times.

1. Keep all merchandise in the rear of the truck. Leave nothing in the cab.
2. Secure the truck when making a delivery. Roll up all windows, lock all doors, and take the keys with you.
3. Do not stop for stranded motorists. This could be a setup for a hijack. If you feel it is necessary to call for assistance, do so at your next stop.
4. Make it a habit to check your rearview mirror to see if you are being followed. If you suspect that you are being followed, obtain a description of the vehicle, the license number and the occupants. Proceed to the local police station; if this is not possible, proceed to your next stop, and call the local police or the office.
5. If you break down, stay with your truck. Leave only to call for assistance.
6. Avoid areas where the threat of theft is high (such as back doors and alleys). If something appears suspicious, do not stop.
7. In the event of a robbery:
 - A. Offer no resistance.
 - B. Stay calm.
 - C. Be observant.

Driver Signature: _____

Witness Signature: _____

FORM NAME:

WILL CALL LOG

FORM NUMBER:

DEA # 18

FUNCTION:

Used to document the pickup of an order by a customer.

WILL CALL LOG

Customer Name _____
Customer Number _____ Invoice Number _____
Date _____ Time _____
Number of Boxes _____ Number of Bags _____
Courier Service Name _____
Drivers Name (Print) _____
Drivers Signature _____
Drivers License Number _____ State _____
Driver ID# (Cab Number, etc.) _____

WILL CALL LOG

Customer Name _____
Customer Number _____ Invoice Number _____
Date _____ Time _____
Number of Boxes _____ Number of Bags _____
Courier Service Name _____
Drivers Name (Print) _____
Drivers Signature _____
Drivers License Number _____ State _____
Driver ID# (Cab Number, etc.) _____

FORM NAME: CONSENT AND RELEASE

FORM NUMBER: DEA #19

FUNCTION: Used during employment application process to obtain applicant's consent for background investigation and drug screening.



CONSENT AND RELEASE:

PLEASE READ THIS NOTICE AND CONSENT FORM CAREFULLY BEFORE SIGNING. YOU WILL BE PROVIDED WITH A COPY OF THIS FORM AT ANY TIME UPON REQUEST.

NOTICE AND CONSENT CONCERNING CONSUMER REPORTS FOR EMPLOYMENT APPLICATIONS AND EMPLOYMENT PURPOSES.

This form, which you should read carefully, has been provided to you because Cardinal Health ("Cardinal Health") will request consumer reports or investigate consumer reports in connection with your application for employment or during the course of your employment with Cardinal Health, if any. These background checks, and/or investigations, will be performed by Cardinal Health, in whole or in part, at Cardinal Health's discretion.

Cardinal Health's applicant background checks and employee investigations will also include the use of consumer reporting agencies to gather and report information to Cardinal Health in the form of consumer or investigative consumer reports, as regulated by federal law. Such reports, if obtained, will be prepared by consumer reporting agencies and may contain information concerning your credit standing or worthiness, character, general reputation, personal characteristics, or mode of living. Cardinal Health is not a consumer-reporting agency.

The type of reports that may be requested from consumer reporting agencies under this policy include, but are not limited to; credit reports, criminal records (for the maximum period permitted by applicable state and federal law), court records, driving records, and/or summaries of educational and employment records and histories. The information contained in these reports may be obtained by a consumer reporting agency, from public records, or through personal interviews with co-workers, neighbors, friends, associates, current or former employers, or other personal acquaintances. Any information contained in such reports may be taken into consideration in evaluating your suitability for employment, promotion, reassignment or retention as an employee.

If Cardinal Health requests an investigative consumer report to be performed by a consumer reporting agency, as defined by federal law, you will receive a notice indicating that the report has been requested no later than three days after the request is made to the agency. This additional notice, if issued, will provide you with further information pertaining to federal law governing investigative consumer reports. You will not receive a notice if Cardinal Health or a person or entity other than a consumer-reporting agency performs the investigation.

Your consent is required by law before Cardinal Health may obtain a consumer report or investigative consumer report from a consumer reporting agency pertaining to your application for employment and thereafter, during the course of your employment, if any, at Cardinal Health's discretion. Your signature below indicates that you have read and understand that Cardinal Health may request and review a consumer report or investigative consumer report regarding your background, and that you consent to the release of reports to Cardinal Health for employment purposes. This information may also be considered for any future decisions concerning your employment, promotion, reassignment or retention as an employee of Cardinal Health. Your signature additionally reflects your understanding that such consent will remain in effect indefinitely until you revoke it in writing, as described below.

8.00

Refusal to consent to a consumer report or an investigative consumer report as required by this notice, or any other attempt to interfere or failure to cooperate with Cardinal Health's lawful investigation, may result in rejection of your application, withdrawal of an offer of employment, or corrective discipline; up to and including termination of employment.

CONSENT STATEMENT:

I have carefully read and understand this notice and consent form and, by my signature below, consent to the release of consumer or investigative consumer reports, as defined above, to Cardinal Health in conjunction with my application for employment. I further understand that this consent will apply during the course of my employment with Cardinal Health, should I obtain such employment, and that such consent will remain in effect until revoked in a written document signed by me.

In the event that I wish to refuse or revoke my consent, I understand that I may do so by: 1. Signing the "Refusal or Revocation of Consent Statement" below, or 2. Sending a signed statement, indicating that I revoke my consent for Cardinal Health to obtain a consumer report or investigative consumer report, and submitting to:

Cardinal Health
Human Resources
7000 Cardinal Place
Dublin, OH 43017

I certify that the information I have provided to Cardinal Health, on this consent and release form, is correct to the best of my knowledge and I understand that any falsifications, misrepresentations, and/or omissions may result in my disqualification for consideration of employment or, if subsequently employed, my dismissal.

Name of Applicant/Employee

Applicant/Employee Signature

Today's Date

REFUSAL OR REVOCATION OF CONSENT STATEMENT:

(DO NOT SIGN UNLESS YOU HAVE DECIDED THAT YOU WILL NOT CONSENT, OR WILL NO LONGER CONSENT, TO CARDINAL HEALTH OBTAINING A CONSUMER REPORT OR AN INVESTIGATIVE CONSUMER REPORT)

I do not consent to Cardinal Health obtaining consumer reports or investigative consumer reports about me in connection with my application for employment or for any other employment purposes. If I have previously granted my consent, I hereby revoke that consent and understand that such revocation will take effect immediately after Cardinal Health receives this written revocation and has actual knowledge to communicate the revocation to those employees or agents who request consumer reports for Cardinal Health.

Name of Applicant/Employee

Applicant/Employee Signature

Today's Date

8.00

FORM NAME: EMPLOYMENT SECURITY INFORMATION

FORM NUMBER: DEA # 20

FUNCTION: Used to conduct background investigations on new employees.



Cardinal Health



Submitted / /

EMPLOYMENT SECURITY INFORMATION

Division: _____ Supervisor: _____

Department: _____ Date of Hire _____

Name: _____ (First) _____ (Middle) _____ (Last) _____

Present Address: _____ (Street) _____ (City) _____ (State) _____ (Zip) _____

Time at residence: _____ County of Residence: _____ Telephone: () _____

Previous Name	(First)	(Middle)	(Last)
Previous Residence	(Street)	(City)	(State) (Zip)
Time at previous residence	County of previous residence		

Social Security Number _____ Drivers License Number _____ State _____

Date of Birth _____ Place of Birth _____ Height _____ Weight _____

Eye Color _____ Color of Hair _____ Marital Status _____ 8.00

Education Verification

Institution/School

City

State

Dates Attended

Degree

Have you ever been convicted of a crime (felony or misdemeanor), or do you have any pending charges? * Yes ___ No ___

If yes, identify the crime, the date of the conviction, the court where the conviction occurred, and the disposition of the case. Please provide any details you feel are relevant. _____

Conviction of a crime will not automatically disqualify you from employment, but will be considered as a part of the overall evaluation of your qualifications for the position sought.

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Do not include information about juvenile convictions in the following states: California, Connecticut, Florida, Georgia, Kansas, Maryland, New Jersey, Oklahoma, Oregon, and West Virginia.

California, do not include information about misdemeanor convictions for which you successfully completed probation or which were otherwise dismissed. Also, do not include information about convictions for possession of a substantial amount of marijuana if the conviction occurred more than 2 years before today's date.

[illegible]

Waiver: I hereby authorize Cardinal Health, its subsidiaries or affiliates, and the Drug Enforcement Administration to make a complete investigation of me, my former business relations and employment, and any business organization or any other person to give full information and records about me. I hereby release Cardinal Health its subsidiaries, affiliates, officers, employees, informants and the Drug Enforcement Administration from liability arising from this investigation. Discovery of false information on this sheet may lead to discharge of my employment with Cardinal Health or its subsidiaries or affiliates.

Signature

Today's Date:

8.00

FORM NAME:

VISITOR LOG

FORM NUMBER:

DEA # 21

FUNCTION:

Used to document any visitor's entering the facility.

VISITOR LOG

[illegible]

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Cardinal**

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CAH SWE 019261

CAH_MDL_PRIORPROD_DEA07_01384124

FORM NAME:

MISCELLANEOUS SECURITY LOG

FORM NUMBER:

DEA # 22

FUNCTION:

Used to document any minor security-related incidents that occur but do not need to be explained in detail (i.e., false alarms, open doors, alarm not set, etc.).

FORM NAME: DEA INSPECTION REPORT

FORM NUMBER: DEA # 23

FUNCTION: Used to document an inspection made by the DEA.

DEA INSPECTION REPORT

This form is to be completed by the Division Manager or his designee and forwarded to the Corporate Compliance Department upon completion of a DEA inspection.

DIVISION: _____

DATE: _____

A. General Information

1. Initiation Date
2. Leader Compliance Investigator
3. DEA Office
4. Closing Date -- Exit Interview
5. Total On-Site Days
6. Total On-Site Person Hours

B. Inventory Accountability Audit

1. Number of items audited

--

a) Description and class of items audited:

2. Audit timeframe in months

--

3. Number of items in variance

--

C. Inspection Focal Points (Check all that apply)

1. Background information
2. Biennial Inventory
3. Recordkeeping
4. DEA Form 222
5. Physical Security
6. Procedural Security
7. Shipping/Receiving Procedures
8. Registration Verification/Customers
9. ARCOS
10. Suspicious Order Monitoring
11. Destructions
12. Losses/Thefts
13. Pre-Employment Screening
14. Will Calls
15. Powers of Attorney
16. Other _____

D. Comments

Please document any significant comments, questions, criticisms made by the inspector during the inspection and exit interview and attach to this report.

E. Resolution (to be completed by Corporate Compliance Department)
Please attach all related documentation.

1. DEA Follow-Up
2. DEA Letter of Admonition
3. DEA Citation
4. Memorandum of Understanding
5. Informal Hearing
6. Formal Hearing
7. Court Proceeding
8. Consent Order
9. Total Violations Acknowledged in M.O.U.
10. Fines Sought
11. Fines Paid
12. Resolution Date

Yes		No	
Yes		No	
Yes		No	
Yes		No	
Yes		No	
Yes		No	
Yes		No	
Yes		No	

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Signature and Title of Person Completing Form

Date

Division Manager's Signature

Date

FORM NAME: **DEA ON-SITE BACKGROUND INFORMATION PACKAGE**

FORM NUMBER: **DEA # 24**

FUNCTION: **Used to provide DEA Investigators with company background information during DEA audits.**

DEA ON-SITE BACKGROUND INFORMATION PACKAGE

SECTION I

FIRM'S BACKGROUND

A.. **Company Name:**

Address:

Telephone Number:

Fax Number:

B. **Type of Firm:**

C. **Corporate Headquarters:**

D. **State of Incorporation:**

E. **Subsidiaries:**

F. **Corporate Officers: (See attached)**

G. **Principle Management Personnel:**
(List all personnel and include the following information)

Name:

Title:

Length of Service:

H. **Type of Business:**

I. **Distribution Area:**

J. **Methods of Distribution (Delivery Companies):**

- K. Hours of Operation: _____
- L. Number of Employees: _____
- M. How long at present location: _____
- N. Controlled substance sales as percentage of total sales: _____

SECTION II **LICENSES AND REGISTRATIONS**
(attach copies of DEA registration and State licenses).

- A. DEA (See attached):
- B. State (See attached):

SECTION III
(Briefly describe when inventories are taken and where records are maintained).

- A. Biennial Inventories: _____

- B. Periodic Inventories: _____

SECTION IV **RECORDS / REPORTS**
(briefly describe the types of records and where maintained)

- A. Purchase Records: _____

- B. Sales Records: _____

- C. Return Records: _____

D. **DEA Form 222 - (blue & brown):** _____

E. **Power of Attorney:** _____

F. **DEA Form 106:** _____

G. **DEA Form 41:** _____

H. **ARCOS Records:** _____

I. **Suspicious/Excessive Customer Purchases:** _____

J. **Customer DEA Registrations and Verifications:** _____

SECTION V

PROCEDURES

(Briefly describe how the following is accomplished with respect to controlled substances).

A. **Receiving:**

B. **Order Filling:**

C. **Shipping:**

D. **Returns:**

SECTION VI

SECURITY

A. **Structure of Building:**

B. **Structure of Vault:**

C. **Structure of Cage:**

D. **Alarm Company:
Address:**

E. **Type of Alarm Hardware:**

F. **Type of Circuit (McCulloh Loop, etc.):**

G. **Notification Procedures:**

H. Who Responds:

I. Response Time:

Alarm Company:

Law Enforcement:

Distribution Center Personnel:

J. Persons with Alarm Keys/Passes:

(List all personnel and include the following information):

Name: _____

Title _____

Length of Service: _____

K. Persons with Access to Vault:

(List all personnel and include the following information)

Name: _____

Title _____

Date of Birth: _____

SS# _____

L. Persons with Access to Cage:

(List all personnel and include the following information)

Name: _____

Title _____

Date of Birth: _____

SS# _____

M. Employee Screening procedures (Describe hiring practices):

Cardinal Health, Inc.: DEA Registered Locations

<i>Distribution Center</i>	<i>Address</i>	<i>DEA Number</i>
Whitmire Dist. Corp. DBA Cardinal Health	7301 Los Volcanes Rd. NW Albuquerque NM 87121	RW0234928
Whitmire Distribution Corp. DBA Cardinal	914 Marcon Blvd. Allentown PA 18103	RW0191938
Whitmire Distribution Corp. DBA Cardinal	801 C St. N.W., Suite B Auburn WA 98001	RW0191813
Whitmire Distribution Corp. DBA Cardinal	2353 Prospect Dr. Aurora IL 60504	RW0231908
Whitmire Distribution Corp. DBA Cardinal	4770 (U) Forest St. Denver CO 80216	RW0192017
Whitmire Distribution Corp. DBA Cardinal	13188 Lakefront Drive Earth City MO 63045	RW0192106
Marmac Distributors, Inc. DBA Cardinal Health	4 Craftsman Road East Windsor CT 06088	RM0125484
Whitmire Distribution Corpora DBA Cardinal	3238 Dwight Road Elk Grove CA 95758	RW0236009
Whitmire Distribution Corp. DBA Cardinal	4 Girbraud Ct. Greensboro NC 27407	RW0243903
Ohio Valley-Clarksburg, Inc. DBA Cardinal Health	6540 Port Road Groveport OH 43125	RR0248179
Whitmire Distribution Corp. DBA Cardinal	7052 Grand Blvd. Ste. 112 Houston TX 77054	RW0191407
Whitmire Distribution Corp. DBA Cardinal	2901 Enloe St. Hudson WI 54106	RW0243725
Whitmire Distribution Corp. DBA Cardinal	7601 NE Gardner Avenue Kansas City MO 64120	RW0191926
Chapman Southeast, Inc. DBA Cardinal Health	2512 West Cott Blvd Knoxville TN 37931	RC0238104

Wednesday, January 05, 2000

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<i>Distribution Center</i>	<i>Address</i>	<i>DEA Number</i>
Cardinal Southeast, Inc. DBA Cardinal Health	2045 Interstate Drive Lakeland FL 33805	RC0182080
CORD Logistics	1135 Heil Quaker Blvd. Ste. 100 LaVergne TN 37086	RC0229965
Cardinal Southeast, Inc. DBA Cardinal Health	1240 Gluckstadt Road Madison MS 39110	RC0221236
National Specialty Services, Inc.	556 Metroplex Dr. Nashville TN 37211	RN0184363
Whitmire Distribution Corp. DBA Cardinal	1351 Doubleday Ontario CA 91761	RW0192168
Daly, James W. Inc. DBA Cardinal Health	11 Centennial Drive Peabody MA 01960	RD0108200
Packaging Coordinators, Inc.	3001 Red Lion Road Philadelphia PA 19114	RP0225284
Whitmire Distribution Corp. DBA Cardinal	3821 East Broadway Phoenix AZ 85040	RW0224294
Whitmire Distribution Corp. DBA Cardinal	4422 South 38th Place Phoenix AZ 85040	RW0191940
Cardinal Southeast, Inc. DBA Cardinal Health	42 Ross Road Savannah GA 31405	RS0187612
Whitmire Distribution Corp. DBA Cardinal	955 West 3100 South South Salt La UT 84119	RW0191419
Cardinal Syracuse, Inc. DBA Cardinal Health	6012 Molloy Rd. Syracuse NY 13211	PC0003044
Whitmire Distribution Corp. DBA Cardinal	27680 Avenue Mentry Valencia CA 91355	RW0216449
Whitmire Distribution Corp. DBA Cardinal	7500 Mars Drive Waco TX 76712	RB0196522
Ohio Valley-Clarksburg, Inc. DBA Cardinal Health	71 Mil-Acres Dr. Wheeling WV 26003	RO0153609
National PharmPak Services, Inc.	3450 East Pike Zanesville OH 43701	RN0209583

Wednesday, January 05, 2000

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<i>Distribution Center</i>	<i>Address</i>	<i>DEA Number</i>
Williams Drug Dist., Inc.	1000 Linden Ave. Zanesville OH 43701	PT0186038
National PharmPak Services, Inc	850 Airport Distribution Drive Zanesville OH 43701	RN0244967
National PharmPak Services, Inc	1000 Linden Avenue Zanesville OH 43701	RN0231427

Wednesday, January 05, 2000

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Cardinal

CONFIDENTIAL

CAH SWE 019275

CAH_MDL_PRIORPROD_DEA07_01384138

FORM NAME: LIMITED POWER OF ATTORNEY

FORM NUMBER: DEA # 25

FUNCTION: Used for a change of pharmacy ownership and continuing operation on a previous owner's DEA registration.

LIMITED POWER OF ATTORNEY

(Name of Registrant)

(Address of Registrant)

(DEA Registration Number)

WHEREAS, _____ (hereinafter referred to as "Seller") and
(hereinafter referred to as "Buyer"), have executed a Purchase Agreement dated
and related documents, all with the intent of transferring a pharmacy _____ currently
known as _____ (the "Pharmacy") and

WHEREAS, the transfer referred to in said Purchase Agreement is to take place,
or has taken place, on or about _____ and

WHEREAS, the parties to the Purchase Agreement and this Power of Attorney desire that
the business carried on at _____ shall continue without interruption
while BUYER obtains a DEA registration and the various licenses necessary in the State of
and until the transfers referred to in said Purchase Agreement take place; and

WHEREAS, such licenses are currently possessed by the Seller.

NOW, THEREFORE, in consideration of the mutual covenants and promises contained in
the Purchase Agreement and related documents, and in an effort to implement the same, I,
_____, who is authorized to sign the current application for registration of the above-
named registrant under the Controlled Substances Act or Controlled Substances Import and
Export Act, have made, constituted, and appointed, and by these presents do make, constitute,
and appoint _____, my true and lawful attorney for me in my name, place, and stead,
to execute applications for books of official order forms and to sign such order forms in
accordance with Section 309 of the Controlled Substances Act (21 U.S.C. 828) and Part 305 or
Title 21 of the Code of Federal Regulations for _____ Pharmacy located at _____
Such appointment shall authorize buyer to take all actions permitted by the undersigned pursuant
to the aforesaid licenses, with respect to the management of the Pharmacy. I hereby ratify and
confirm all that said Attorney-in-Fact shall lawfully do or cause to be done by virtue hereof,
including the use of the DEA number of Seller until such time as a new DEA number and State
pharmacy licenses are issued from the proper federal and state authorities.

IT IS FURTHER UNDERSTOOD that after the Closing Date in the Purchase Agreement, at such time as the undersigned no longer owns the assets of the pharmacy aforementioned, the operation of said pharmacy shall be solely in the control of Buyer and that nothing herein shall be construed so as to cause Buyer to be deemed the employee of the undersigned for any reason whatsoever, and that no action taken by Buyer shall give rise to any liability of the undersigned to any third party.

It is agreed by both parties that this appointment of Attorney-in-Fact shall terminate on the first to occur of Buyer obtaining all necessary licenses to operate the Pharmacy, or , 199 . (Power of Attorney cannot extend beyond 45 days of closing.)

By: _____

I, _____, accept the foregoing appointment, and I represent and warrant that I am a registered pharmacist, licensed to practice pharmacy in the State of _____, and I am the person named herein as Attorney-in-Fact and, that the signature affixed hereto is my signature.

By: _____

FORM NAME: DEA AND ARCOS DIVISION AUDIT RECAP

FORM #: DEA # 26

FUNCTION: Used to facilitate compliance with DEA record keeping and reporting requirements and assist the Corporate Compliance Department in monitoring divisional compliance and identifying potential problem areas.

DISTRIBUTION: This form is to be completed at the end of each month. One copy must be sent to the Corporate Compliance Department. One copy to your group office if applicable. One copy must remain on file at the division.



DEA & ARCOS DIVISION AUDIT RECAP

te _____

Division _____

1.	DP Number	Product	Counts	QOH	Variance
			Actual		
	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____

Discrepancies to counts and follow-up action taken: _____

2. Morgue - no controlled substances in morgue or in staging area for customer returns.
COMPLIANCE Yes _____ No _____
3. Receiving Area - No controlled substances left out or unattended in receiving.
COMPLIANCE Yes _____ No _____
- 4(a). Review of prior month's brown customer purchase copy of narcotic blanks.*
COMPLIANCE Yes _____ No _____
- 4(b). Review of prior month's DEA green copy of form 222.
COMPLIANCE Yes _____ No _____
Review of prior month's blue receiving copy of narcotic blanks for purchases
COMPLIANCE Yes _____ No _____
Division Manager or designee has approved and initialed blanks for excessive customer purchases.
COMPLIANCE Yes _____ No _____
7. DEA form 106 submitted timely to DEA for variances, losses or thefts.
Date variance occurred _____ Date loss/theft occurred _____
Date form 106 was submitted _____ Date form 106 was submitted _____
(attach copy of Form 106)
8. DEA Form 41 submitted for destruction and verification of ARCOS submission.
COMPLIANCE Yes _____ No _____
9. Excessive purchase report on file with copies of contact sheets sent to state and local DEA offices.
COMPLIANCE Yes _____ No _____
10. ARCOS and DEA Submission control form with return receipt copy, from prior month.
COMPLIANCE Yes _____ No _____
- 11(a). Month-end physical cycle counts for vault and cage with no variances.
VARIANCES Yes _____ No _____ If no, how many new variances this month? _____
- 11(b). Compliance to follow-up variance procedures.
Yes _____ No _____
12. ARCOS errors report researched and resubmitted.
Yes _____ No _____

Attach copies of blanks found not to be in compliance.

Division Manager's Signature

EXHIBIT A

Program : QINV240J WHITHIRE DIST CORP- MILWAUKEE Run Date: 12/30/94
 Report : QINV246R CONTROLLED SUBSTANCES INVENTORY Run Time: 19:49
 Whse No.: 3034 Page: 1

The following report contains a complete inventory
 of Controlled Substances stocked at this distribution
 center warehouse at the close of business 12-30-94,
 in compliance with the Code of Federal Regulations:

#1304.13 BIENNIAL INVENTORY, and

ARCOS ANNUAL INVENTORY

Steve Krane
 Witness

Dist Center Manager

12/30/94
 Date

12/30/94
 Date

60A*42--	088-749	242	XANAX 100	TABS 0.25MG 000009-0029-01 UPJOHN COM	A
60A*51	258-350	118	APAP/COD 1000	#3 TABS 30/300 000093-0150-10 LEMMON CO.	A
60A*52	859-001	19	ALPRAZOLAM 500	TABS 1MG 000781-1328-05 GENEVA PHA	A
60B*21	097-403	39	WYCESIC 100	TABS 65/650 000008-0085-01 WYETH-AYER	A
60B*22	088-757	228	XANAX 100	TABS 0.5 MG 000009-0055-01 UPJOHN COM	A
60B*23	076-252	12	P. ORINAL	TABS	A